

The **Colorado** Profile:

Prioritizing funding and integration

Use of Evidence-based Guidelines in
State Tobacco Control Programs

Prepared by
The Center for Tobacco Policy Research at
Washington University in St. Louis

Acknowledgements

This profile was developed by:

Jennifer Cameron
Lana Wald
Laura Bach
Stephanie Herbers
Max Bryant
Laura Brossart
Douglas Luke

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*For more information or to obtain a copy of this report,
please contact:*

Center for Tobacco Policy Research
George Warren Brown School of Social Work
Washington University in St. Louis
700 Rosedale Ave, CB 1009
St. Louis, MO 63112
<http://ctpr.wustl.edu>

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Executive Summary

Introduction

There has been a significant amount of research done on what works to curb tobacco use. Many agree that the evidence base for tobacco control is one of the most developed in the field of public health. However, the advancement in the knowledge base is only effective if that information reaches those who work to reduce tobacco consumption. Evidence-based guidelines, such as the Centers for Disease Control and Prevention's *Best Practices Guidelines for Comprehensive Tobacco Control Programs (Best Practices)*, are a key source of this information. However, how these guidelines are utilized can significantly vary across states.

This profile presents findings from an evaluation conducted by the Center for Tobacco Policy Research at Washington University in St. Louis that aimed to understand how evidence-based guidelines were disseminated, adopted, and used within state tobacco control programs. Colorado served as the fifth case study in this evaluation. The project goals were two-fold:

- Understand how Colorado partners used evidence-based guidelines to inform their programs, policies, and practices;
- Produce and disseminate findings and lessons from Colorado and other states so that readers can apply the information to their work in tobacco control.

Findings from Colorado

The following are highlights from Colorado's profile. Please refer to the complete report for more detail on the topics presented below.

- Evidence-based guidelines were generally thought to provide the foundation for the program and were used as an advocacy tool.
- The Colorado Department of Public Health and Environment (CDPHE) served as a primary source for guideline dissemination.
- The integration of Colorado's tobacco grant program and staff with other chronic disease efforts enhanced partners' decision-making by providing new perspectives from individuals outside of tobacco control.
- Every Colorado partner was aware of the CDC's *Best Practices* and primarily used the guideline to advocate for funding from policymakers and develop strategic plans.
- Despite the acknowledged importance of evidence-based guidelines, some challenges were identified with utilizing them.
 - Due to significant budget cuts, CDPHE could not fund all of *Best Practices'* recommended categories.
 - Evidence-based guidelines lacked sufficient information on how to effectively address populations with tobacco-related disparities.
- Colorado partners emphasized the need for further direction and guidance from the CDC, such as:
 - Guidance on how to strengthen the organizational aspects of the process of integrating the tobacco grant program with other chronic disease initiatives; and,
 - Guidance on community-based initiatives, specifically additional data and strategies for more local level efforts.

Introduction

Project overview

States often struggle with limited financial and staffing resources to combat the burden of disease from tobacco use. Therefore, it is imperative that efforts that produce the greatest return on investment are implemented. There has been little research on how evidence-based interventions are disseminated and utilized by state tobacco control programs. To begin to answer this question, the Center for Tobacco Policy Research at Washington University in St. Louis conducted a multi-year evaluation in partnership with the CDC Office on Smoking and Health (CDC OSH). The aim of this project was to examine how states used the CDC's *Best Practices for Comprehensive Tobacco Control Programs (Best Practices)* and other evidence-based guidelines for their tobacco control efforts and to identify opportunities that encouraged guideline use.

Qualitative and quantitative data from key partners in eight states were collected during the project period. States were selected based on several criteria, including funding level, lead agency structure, geographic location, and reported use of evidence-based guidelines. Information about each state's tobacco control program was obtained in several ways, including: 1) a survey completed by the state program's lead agency; and 2) key informant interviews with approximately 20 tobacco control partners in each state.

State profiles

This profile is part of a series of profiles that aims to provide readers with a picture of how states accessed and utilized evidence-based guidelines. This profile presents data collected in June 2010 from Colorado partners. The profile is organized into the following sections:

- **Program Overview** – provides background information on Colorado's tobacco control program.
- **Evidence-based Guidelines** – presents the guidelines we asked about and a framework for assessing guideline use.
- **Dissemination** – discusses how Colorado partners learned of new guidelines and their awareness of specific tobacco control guidelines.
- **Adoption Factors** – presents factors that influenced Colorado partners' decisions about their tobacco control efforts, including use of guidelines.
- **Implementation** – provides information on the critical guidelines for Colorado partners and the resources they utilized for addressing tobacco-related disparities and in communication with policymakers.
- **Conclusions** – summarizes the key factors that influenced use of guidelines based on themes presented in the profile and current research.

Quotes from participants (offset in green) were chosen to be representative examples of broader findings and provide the reader with additional detail. To protect participants' confidentiality, all identifying phrases or remarks have been removed.

Program Overview

Colorado's tobacco control program

Colorado's tobacco grant program, the Colorado Department of Public Health and Environment (CDPHE), functioned as the lead agency for Colorado's tobacco control efforts. Formerly known as the State Tobacco Education and Prevention Partnership (STEPP), the program was supported by funds from Amendment 35, a tobacco excise tax increase passed by a statewide ballot initiative in 2004. Sixteen percent of the tobacco tax revenue was allocated to tobacco control efforts. The 2004 ballot initiative also established the Tobacco Education, Prevention and Cessation Grant Program Review Committee (Review Committee) to oversee the program, ensure compliance with state legislation, and formulate grant funding recommendations.

Colorado was one of four chronic disease integration pilot projects funded by the CDC. CDPHE was chosen to be a part of the CDC pilot in 2008, although they had already begun the integration process on their own in 2006. The process included consolidating staff and creating the Center for Healthy Living and Chronic Disease Prevention. The Center for Healthy Living and Chronic Disease Prevention had developed an integrated work plan and was undergoing reorganization efforts, which included integrating the tobacco grant program and staff with other chronic disease efforts. Lead agency staff noted that the most important outcomes thus far from integration were centralizing functional aspects, such as policy expertise, and developing cross-cutting programs (e.g., environmental change, physical activity, nutrition). These changes were implemented in order to improve overall health outcomes by providing a more comprehensive approach to serving populations with the greatest burden of chronic disease, including tobacco-related illness.

Colorado's program incurred significant funding cuts in FY2010. In response to economic crises, the state legislature passed a bill that decreased CDPHE's budget by \$8 million and Governor Ritter passed an executive order that reduced the budget by another \$7 million. Consequently, the program's budget dropped from \$27.5 million in FY2009 to \$12.4 million in FY2010, meeting only 22.8% of the amount recommended by the CDC for a comprehensive tobacco control program in Colorado. CDPHE, which had been seen as a leader in the tobacco control movement, was thus forced to discontinue or cut back on many of the prevention and cessation projects it funded.

Colorado's tobacco control partners

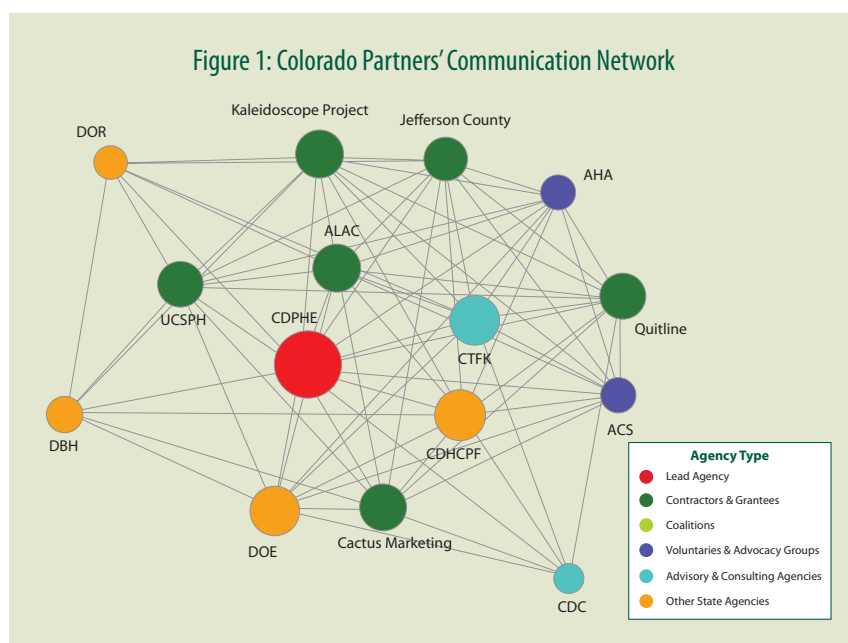
Colorado's tobacco control efforts involved a variety of partners. Partners included health voluntaries, evaluators, other state agencies, a marketing agency, and national organizations. Some partners also had secondary roles as members of the Review Committee. Twenty individuals from 15 organizations were identified as a sample of key members of Colorado's tobacco control network. The majority of Colorado partners had extensive experience in tobacco control, averaging nine years of involvement. Many partners worked under the broader auspices of chronic disease and tobacco control was one of several areas they addressed. Table 1 presents the list of partners who participated in the interviews.

Table 1: Colorado Tobacco Control Partners

Agency	Abbreviation	Agency Type
Colorado Department of Public Health & Environment	CDPHE	Lead Agency
Cactus Marketing Communication	Cactus Marketing	Contractors & Grantees
National Jewish Health	Quitline	Contractors & Grantees
University of Colorado School of Public Health, Surveillance & Evaluation	UCSPH	Contractors & Grantees
American Lung Association of Colorado	ALAC	Contractors & Grantees
Jefferson County Public Health Department	Jefferson County	Contractors & Grantees
The Kaleidoscope Project	Kaleidoscope	Contractors & Grantees
American Heart Association	AHA	Voluntaries & Advocacy Groups
American Cancer Society, Great West Division	ACS	Voluntaries & Advocacy Groups
Colorado Department of Human Services, Division of Behavioral Health	DBH	Other State Agencies
Department of Revenue	DOR	Other State Agencies
Department of Education, Coordinated School Health	DOE	Other State Agencies
Colorado Department of Health Care Policy & Financing	CDHCPF	Other State Agencies
Campaign for Tobacco Free Kids	CTFK	Advisory & Consulting Agencies
Centers for Disease Control & Prevention	CDC	Advisory & Consulting Agencies

Communication between Colorado partners

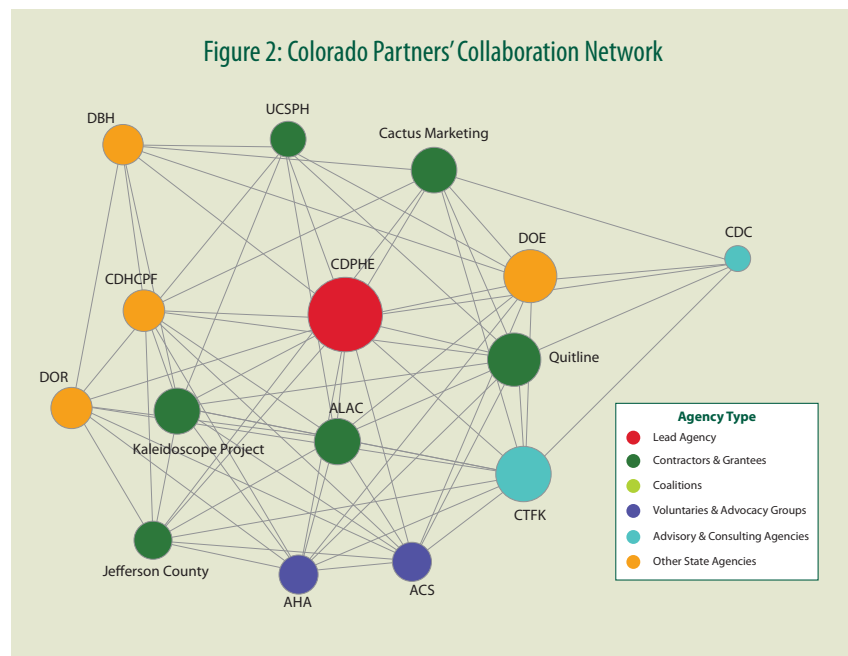
To gain a better sense of partners’ relationships in Colorado, partners were asked about their interaction with other tobacco control organizations. Partners were asked how often they had direct contact (e.g., meetings, phone calls, or e-mails) with other partners within their network in the past year. In the figure to the right, a line connects two partners if they had contact with each other on more than a quarterly basis. The size of the node (dot representing each agency) indicates the amount of influence a partner had over contact in the network. An



example of having more influence, or a larger node, was seen between Kaleidoscope Project, CDPHE, and Cactus Marketing. Kaleidoscope Project did not have direct contact with Cactus Marketing, but both had contact with CDPHE. As a result, CDPHE acted as a bridge between the two and thus, had more influence within the network. Communication within Colorado displayed a relatively decentralized structure among partners in which network members had contact with many agencies and did not rely on one main agency to facilitate communication.

Collaboration between Colorado partners

Partners were also asked to indicate their working relationship with each partner with whom they communicated. Relationships could range from not working together at all to working together as a formal team on multiple projects. A link between two partners indicates that they at least worked together informally to achieve common goals. Partners were not linked if they did not work together or only shared information. Node size is based on the amount of influence a partner had over collaboration in the network. A partner was considered influential if he or she connected partners who did not work directly with each other. For example, ACS and UCSPH did not work directly with one other, but both worked with Quitline. Quitline acted as a “broker” between the two agencies, and, as a result, is represented by a larger node. CDPHE had the most influence over collaboration among partners as demonstrated by its larger node size. This confirms its role as the lead agency for Colorado’s tobacco control efforts and indicates it had working relationships with many partners in the state.



Evidence-based Guidelines

There are a number of evidence-based guidelines for tobacco control, ranging from specific strategies to broad frameworks. Below in Figure 3 are the set of specific guidelines partners were asked about during their interviews.

Partners also had the opportunity to identify additional guidelines or information they used to guide their work. Other resources identified by Colorado partners included:

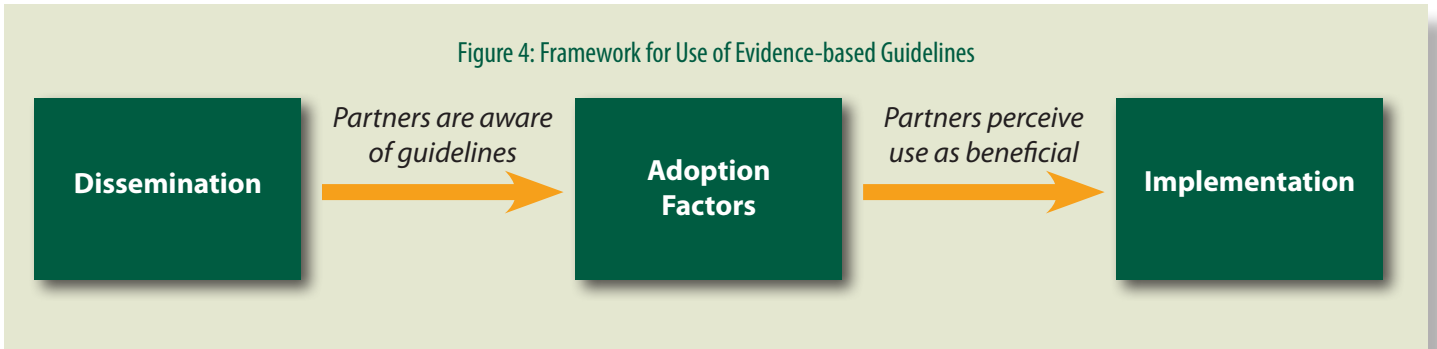
- Surgeon General's reports;
- Guidelines produced by the Joint Commission on the Accreditation of Healthcare Organizations;
- Curriculum recommendations from the U.S. Department of Education's Office of Safe and Drug-Free Schools;
- National Cancer Institute State of the Science reports;
- Information from the Substance Abuse and Mental Health Services Administration; and,
- Resources developed by Colorado State University.

Figure 3: Evidence-based Guidelines for Tobacco Control



Research has shown that the use of evidence-based practices, such as those identified in these guidelines, results in reductions in tobacco use and subsequent improvements in population health. Whether an individual or organization implemented evidence-based practices depended on a number of factors, including capacity, support, and available information. The remainder of this report will look at how evidence-based guidelines fit into this equation for Colorado. The framework below will guide the discussion, specifically looking at which guidelines Colorado partners were aware of, which ones were critical to partners' efforts, and how guidelines were used in their work.

Figure 4: Framework for Use of Evidence-based Guidelines



Dissemination

How did partners define “evidence-based guidelines”?

Colorado partners were asked to describe what came to mind when they heard the term “evidence-based guidelines.” Many partners listed titles of specific guidelines, most often those produced by the CDC. Additionally, partners defined evidence-based guidelines as practices or interventions that had been proven to work based on research and evaluation by credible organizations.

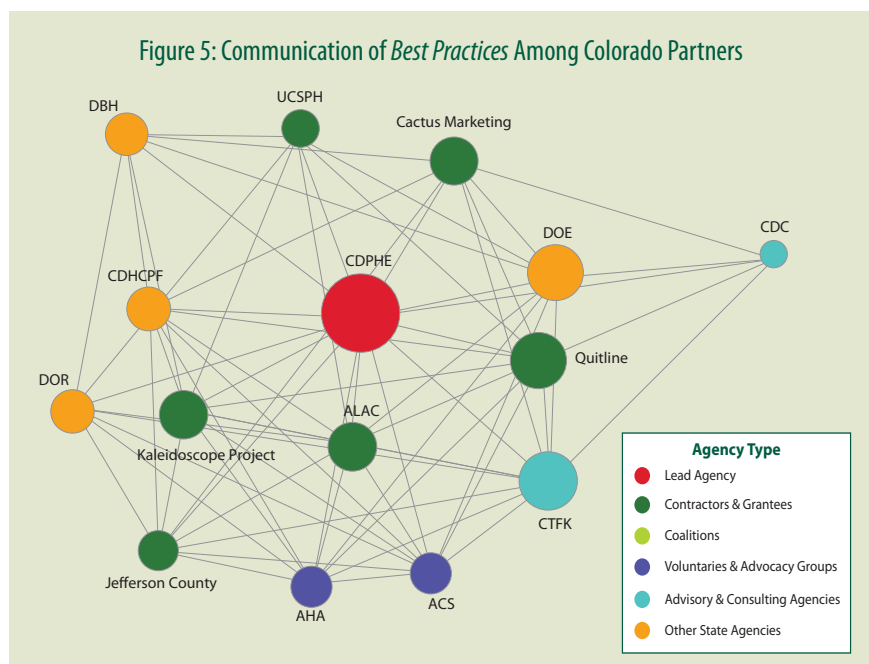
- ⋮ [Evidence-based guidelines] are things that have been tested in the field that again, we know make a difference, and so those are the things that I tend to prioritize and support more.
- ⋮ [Evidence-based guidelines] are recommendations from expert groups who have reviewed all of the available evidence that relates to the specific topic being guided.

How did partners learn of evidence-based guidelines?

Partners were made aware of new guidelines through meetings, trainings, and conferences at both the state and national level. Within the state, CDPHE was most often cited as an important source for dissemination of evidence-based guidelines. Information was most frequently distributed via electronic communication and internal staff meetings. National contacts, particularly at the CDC, were mentioned as additional resources for evidence-based guideline dissemination.

- ⋮ We get the announcements from CDC and others that [evidence-based guidelines] are coming out. CDC tends to keep us in the loop as far as what is coming.

To gain a better understanding of communication about evidence-based guidelines, Colorado partners were asked whom they talked to about CDC’s *Best Practices*. In Figure 5, a line connecting two partners indicates they talked about *Best Practices* with one another. The size of the node reflects the number of agencies each partner communicated with about the guideline. For example, CDPHE most often talked with other agencies about *Best Practices*, resulting in the largest node size. This falls in line with CDPHE frequently being identified by partners as a source for guideline dissemination.



What tobacco control guidelines were partners aware of?

Best Practices was the most well-known guideline in Colorado. All of the partners interviewed recalled at least hearing of *Best Practices*. Most partners referenced *Best Practices* frequently and all partners had referenced the guide within the past year. At least half of the partners were aware of the remaining guidelines, with the exception of *Introduction to Process Evaluation in Tobacco Use Prevention and Control*.

Table 2: Number of Partners Aware of Tobacco Control Guidelines

Guideline	# of Partners
Best Practices for Comprehensive Tobacco Control Programs	20/20
Tobacco Control Monograph Series	16/20
The Guide to Community Preventive Services: Tobacco	15/20
Designing and Implementing an Effective Tobacco Counter-Marketing Campaign	15/20
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	15/20
Ending the Tobacco Problem: A Blueprint for the Nation	14/20
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	14/20
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	13/20
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	13/20
Best Practices User Guide Series	11/20
Key Outcome Indicators for Evaluating Tobacco Control Programs	10/20
Introduction to Process Evaluation in Tobacco Use Prevention and Control	9/20

Adoption Factors

What did partners take into consideration when making decisions about their tobacco control efforts?

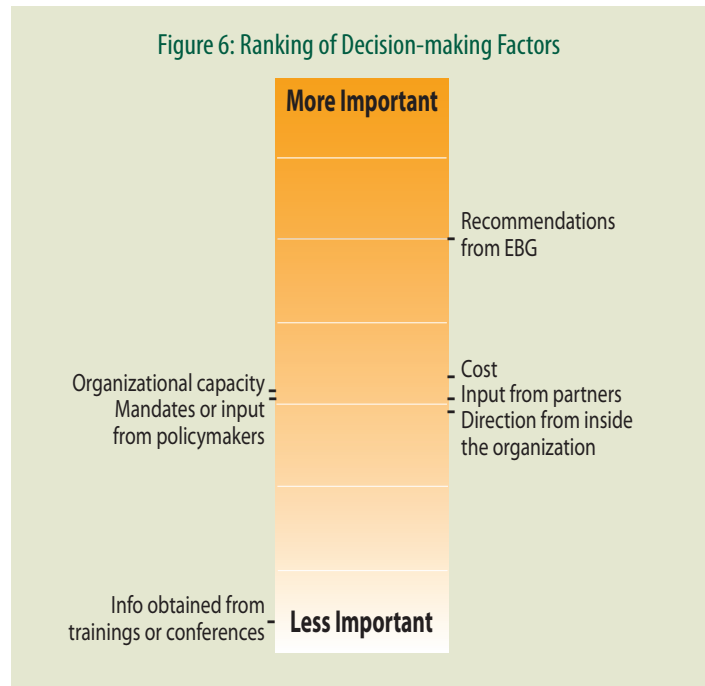
Many factors were taken into consideration by Colorado partners when making decisions about their tobacco control efforts. When asked to rank several factors in their importance for making decisions about their tobacco control efforts, 60% of partners ranked recommendations from evidence-based guidelines as the most important factor; 85% ranked it in their top three. Guidelines, particularly *Best Practices*, provided a foundation and justification for partners' specific interventions.

- Where we start is *Best Practices* and the things that are handed down by CDC.
- [Evidence-based guidelines] give you a foundation from which to begin to have the conversations about what you should be doing and really focusing on what works.

Cost and organizational capacity, perceived to be inextricably linked, also played an important role in partners' decision-making. In order to effectively implement programs, partners needed sufficient funding as well as appropriate staff capacity. Partners also noted that due to the recent budget constraints, cost had become increasingly more important in their decision-making process.

- Cost and organizational capacity [are important] because you have to have capacity and a certain amount of funding in order to make progress.
- The truth is, right now cost is probably number one because we entered this fiscal crisis. But three years ago when we were planning the program according to how it was originally created to be funded, cost was something we were aware of, but it probably was not number one.

Figure 6: Ranking of Decision-making Factors



Additionally, partners valued input from their partners and relied on them as resources when making decisions. Partners stated that in order to accomplish their goals, it was important to engage partners and establish consensus.

- If you don't really know where your partners are coming from, then it's really hard to get anywhere...if you're not on the same page, it's not going to happen.
- [Partners] are going to have to help us implement the program, or the guidelines, or the policy, and so they must be engaged.

How did organizational characteristics influence partners' decisions about their tobacco control efforts?

Colorado partners felt that their leadership was supportive, innovative, and knowledgeable. These leadership characteristics helped to facilitate partners' decision-making efforts.

- We have an excellent mix of leadership in our organization of folks that are really well read and confident of what works out there, and who are willing to take some risks.
- The Department of Public Health has really supported me over the past two years... they really supported me and encouraged me to just do what I said I was going to do, and they've never stopped supporting me in my work.

Partners also found that a creative culture facilitated their decision-making. In order to accomplish their goals, partners oftentimes had to come up with innovative ideas for their implementation efforts. Partners pointed out that the tobacco program's integration with chronic disease enhanced innovation by providing new perspectives from individuals outside of tobacco control.

"I think the integration [of the tobacco grant program with chronic disease] is a big driver in terms of innovation and creativity."

- The beauty of integration [is] having the different disciplines working together in a unit... it allows people to think outside of their stovepipes a lot more, and I think simply because of that, it increases the possibility of new ideas, or the possibility of the permutations of new ideas than when you're just sort of thinking how you usually think.

Some lead agency staff mentioned having dual roles by acting as sitting members on the Review Committee, in addition to their CDPHE position. These partners ultimately had to review themselves, therefore challenging the ability of members to be open and honest. Partners found that a culture built on trust and open communication facilitated their decision-making. When this was inhibited, it was difficult for partners to move forward with their tobacco control efforts.

- We have a novel, probably unusual structure in our review committee in that the program staff members actually sit as members of the review committee as well. So in effect, they are asked to review themselves, and that's been awkward. It took several years of heavy lifting to reach a point where we were satisfied that we had worked through the issues and could trust each other and could rely on each other to act as independent thinking members rather than one side against the other.

What facilitated or hindered use of evidence-based guidelines?

Most partners found value in evidence-based guidelines because they promoted proven practices and provided a foundation to support their efforts. Additionally, partners noted that evidence-based guidelines provided strong parameters that helped prioritize their efforts.

- You have a reference point, or you have a foundation to build from, and you can set limits on what you fund and what you don't fund.

Furthermore, partners found evidence-based guidelines to be a useful tool in facilitating communication with policymakers. Partners stated that because evidence-based guidelines described approaches that were proven to work, they could confidently rely on them to defend their efforts.

- I think [evidence-based guidelines] give us a very useful tool in which to guide not only advocacy efforts, but then inform legislators in a very believable way.
- [Evidence-based guidelines] give you something tangible, that have been proven to work, [and] we can actually model and get results from [them]. So there's no doubt; there's no wavering. [They are] a strong foundation for you to promote what it is that you're doing.

Although the guidelines, particularly Best Practices, did provide direction on what areas to fund, CDPHE noted that they could not fund all of the recommended components due to budget cuts. Grantees and community partners expected their programs to remain funded in order to maintain Best Practices' recommendations for a comprehensive program even when the state experienced significant funding cuts. It was very difficult to prioritize where funding should be allocated, when Colorado did not have CDC's recommended level of funding.

"The biggest challenges are that we can't do everything [Best Practices] tells us to do because we don't have the budget to do it, so we really have to pick and choose wisely. We have to prioritize."

- I think the challenges are how these documents are interpreted by others, and I would say *Best Practices* is the one that has been the most challenging, because given our limited resources, the expectations from grantees and community partners are, "Well, you should have a comprehensive tobacco control program, so you should still be funding all of these pieces, because it says so in the *Best Practices*, and that's what comprehensive tobacco control programming is."

Additionally, partners felt that evidence-based guidelines did not provide sufficient information on effective strategies for working with populations with tobacco-related disparities. The lack of specific direction created difficulties in determining how to apply the guidelines to populations with tobacco-related disparities.

- I think the challenge is not knowing for sure if that evidence-based practice really works in segments of the community.
- [Evidence-based guidelines] aren't as proven within disparate populations and you want a companion piece to go with it to show what the effective strategies are to address tobacco in those populations.

Implementation

Which guidelines were critical for Colorado’s tobacco control partners?

Colorado partners were aware of a number of evidence-based guidelines and reports. However, several guidelines were identified as critical resources when partners were asked to group guidelines into one of three categories: 1) *Critical* for their tobacco control efforts; 2) *Not critical, but useful* for their tobacco control efforts; and 3) *Not useful* for their tobacco control efforts. The following are the guidelines identified most frequently as critical resources for Colorado partners.

Best Practices for Comprehensive Tobacco Control Programs

All Colorado partners were aware of the CDC’s *Best Practices*, and 80% identified it as a critical resource for their tobacco control efforts. Partners most often used *Best Practices*’ funding recommendations to advocate for more funding. Some partners also referred to *Best Practices* for strategic planning.

When we’re looking at putting together work plans and looking at how we should be moving forward [we refer to *Best Practices*].

I would say [*Best Practices*] is very helpful for advocacy purposes too. So anytime we’re updating what the program is doing, and also with budget reductions, we can refer to *Best Practices* and say, “Colorado receives this much money, but for us to have a comprehensive tobacco control program with the greatest impact, we would need \$54 million.”

Table 3: Percentage of Partners Who Identified Guideline as a Critical Resource

Guideline	% of Partners*
Best Practices for Comprehensive Tobacco Control Programs	80%
The Guide to Community Preventive Services: Tobacco	80%
Key Outcome Indicators for Evaluating Tobacco Control Programs	73%
Clinical Practice Guidelines: Treating Tobacco Use and Dependence	69%
Ending the Tobacco Problem: A Blueprint for the Nation	57%
NACCHO 2010 Program and Funding Guidelines for Comprehensive Local Tobacco Control Programs	44%
Designing and Implementing an Effective Counter-Marketing Campaign	40%
Telephone Quitlines: A Resource for Development, Implementation, and Evaluation	36%
Best Practices User Guide Series	36%
Introduction to Process Evaluation in Tobacco Use Prevention and Control	33%
Introduction to Program Evaluation for Comprehensive Tobacco Control Programs	31%
Tobacco Control Monograph Series	27%

* Based on partners who were aware of the guideline

Revisions to the CDC *Best Practices*

In 2007, *Best Practices* was revised. To find out how these changes were perceived, Colorado partners were asked additional questions about *Best Practices*. Most partners were aware of the 1999 version and the specific changes that were made. Partners found that the revised *Best Practices* provided a clearer description of a fully funded program. Partners noted that by taking into account state demographics, the updated funding recommendations were more state-specific. In addition, many felt the consolidation of categories in the 2007 version increased comprehension, particularly how communities fit into the overall statewide efforts.

- I appreciated that they combined the state and community interventions together. I think in the past we've done our work based on sectors and segmented out communities, and I thought it helped to pull communities back together.
- I think [the 2007 *Best Practices*] did a better job of defining what a fully funded program looks like. . . I think before it was more of a generic formula. This time they really took into consideration the specifics of the demographic and the amounts they were recommending for each state in order to be fully funded.

The Guide to Community Preventive Services: Tobacco

Of those partners aware of *The Guide to Community Preventive Services*, or the “*Community Guide*”, 80% identified it as a critical resource. The *Community Guide* served as an important resource for partners when prioritizing services, particularly during budget shortfalls. Partners also felt the *Community Guide* was critical due to its provision of evidence-based interventions not only for tobacco, but also other public health areas. As such, the guideline aligned well with Colorado’s focus on integrating with chronic disease.

- When we got funding cut and we had to prioritize what we called core services, the *Community Guide* was. . . probably the main ranking criteria. So if it was in here as a best practice, then we designated it as a core service.
- This is the core evidence base of work we should be doing. And now we're not only doing it in tobacco, but we're doing it in physical activity and nutrition, and all of our other programming too. It's really a key source for us.

Key Outcome Indicators for Evaluating Comprehensive Tobacco Control Programs

Of those aware of the *Key Outcome Indicators*, 73% rated it as critical to their work. Partners used this guideline for evaluation work, particularly when developing logic models, designing surveys, and preparing work plans.

- In order to build a program, I went [to the *Key Outcome Indicators*] for the logic model for secondhand smoke programs and youth programs and made sure that we're designing our programs so that we're getting the short-term changes and the long-term impact.

Clinical Practice Guidelines: Treating Tobacco Use and Dependence

Sixty-nine percent of Colorado partners aware of the *Clinical Practice Guidelines* cited it as a critical resource. The guideline was used to direct partners' cessation efforts. Specifically, it served as justification for requiring insurance companies to cover cessation treatments and for determining Quitline cessation counseling methods.

- ⋮ We just passed legislation that's requiring coverage for preventive benefits... So when [the *Clinical Practice Guidelines*] get updated, then the insurance companies have to comply with the updates. So they're a great foundation for doing the policy work.
- ⋮ [We have used the *Clinical Practice Guidelines* when] working and contracting with our Quitline provider and what kinds of things are in there determined what we should be doing.

Ending the Tobacco Problem: A Blueprint for the Nation

Of the partners aware of the Institute of Medicine's *Ending the Tobacco Problem: A Blueprint for the Nation* (*IOM Report*), 57% ranked it as a critical resource for their tobacco control efforts. Partners utilized this guideline for funding allocation recommendations, writing grant proposals, and working with coalitions and policymakers.

- ⋮ [The *IOM Report* is helpful when] informing legislators and committees. When we're testifying we make reference a lot, or I do, to the *IOM Report*, making sure legislators are familiar with it, they know the research behind it and the messages that are in it. So I use this a lot with legislators.

"I've used [CDPHE], and not just documents, but people at [CDPHE] for resources, particularly in areas that were very, very gray areas for me. I've had lots of support from the program manager that's working in health disparities."

What resources were used to address tobacco-related disparities?

Colorado partners primarily used statewide surveillance data, such as the Tobacco Attitudes and Behavior Survey (TABS) and the Behavioral Risk Factor Surveillance System (BRFSS), to identify populations with tobacco-related disparities.

- ⋮ [We look] at the information we have from surveys, BRFSS data, of who the smokers are in the state and how do we focus on them.

Partners looked to their colleagues, individuals in the community, and experts on populations with tobacco-related disparities to provide knowledge and direction for addressing disparities. CDPHE and the Tobacco Disparities Advisory Committee (TDAC) served as resources for partners by providing information on ways to address tobacco-related disparities.

- ⋮ We have a couple of staff members who are very, very knowledgeable in who the resources are in terms of people across the state, what resources are online and in books, so I'd say they'd be my first stop if I wanted to know something.
- ⋮ I've gone to several [TDAC] meetings where our grantees are all working on disparities efforts so there's a grantee who is working with the LGBT community, one who's working to look at strategies for low SES and so on and so forth, so TDAC serves as a forum for connecting with those grantees.

Some partners had referenced guidelines, such as *Best Practices*, in their work with populations with tobacco-related disparities. Partners typically used *Best Practices* for general guidance, but felt that it lacked specific strategies for sub-populations. Partners noted that they were aware of the populations with tobacco-related disparities in Colorado, but had not been successful in changing their tobacco-related behaviors. Therefore, partners suggested using focus groups to obtain more in-depth information on those populations that had not been affected by traditional interventions.

- It's a wish...it really is a wish that we get further study, or evidence-based practices, just to see how effective they are in some of these sub-populations.
- I think the best way for us to approach [disparities] is having individuals [from] those populations [participate in] focus groups, larger study areas that look at those groups, and providing information right here in the state.

What resources were used to communicate with policymakers?

CDPHE staff did not have direct communication with policymakers. Instead, they communicated information through legislative liaisons. However, two legislators sat on the Review Committee, which gave some CDPHE staff the opportunity to work directly with policymakers. Partners wanted to illustrate their program's effectiveness, particularly when budgets were limited. Evidence-based guidelines and data, such as information from *Best Practices* and surveillance data, were shared with the legislators on the Review Committee.

- We have the senate majority leader on our Review Committee. Now the department has a policy that we can't talk directly with legislators, or legislative officials unless it goes through the department, but since he's on the Review Committee, we can have direct access to him, so it's a unique situation, and it's good to have him in that role.

"So [because of] the budget reductions, we got a lot of calls from the budget office, and we tried to focus on the impact and the effectiveness of the program. *Best Practices* and a lot of surveillance evaluation data [were used as references]."

Colorado's coalitions and advocacy groups were able to have direct communication with policymakers and often shared specific data from their community. TABS and the Youth Risk Behavior Survey (YRBS) provided much of this data. Partners found that translating data on a local level (e.g., the impact of tobacco taxes for legislators' communities) was most relevant to policymakers. Partners also shared predictions for Colorado based on comparisons to other states to illustrate the possible ramifications of cutting CDPHE's budget. Emphasis was placed on national rankings, program funding, use rates, and expected cost to the policymakers' constituencies.

- We talk about money to their counties, the vote of Amendment 35 Tobacco Tax, youth rates, what exactly is happening in their community.
- We do a lot of national ranking just to share with legislators how far they've dropped, and if they consider another budget cut, how much further they would drop, and what they could anticipate in terms of increased rates with youth and adults as a result of those cuts.

What other resources were needed?

Colorado partners expressed the need for additional data and strategies for working at the local level. Partners also wanted information available regarding other states' initiatives and their outcomes. Partners felt that having this information continually updated and located in an easily accessible and user-friendly venue would benefit their efforts.

- Help with getting lower level data, like sub-county data on tobacco utilization...help with letting us get to drill down because we realize we need to do more community-based efforts as opposed to statewide efforts to really get to the problem.
- A much more dynamic way for states to share insights, content, campaigns, information, that's more user-friendly, more dynamic, more coordinated.

Additionally, Colorado partners expressed their concern that local public health agencies were not as valued by legislators as in previous years. There was a fear that grantees' funding would be cut due to budget cuts to CDPHE. Partners felt that they should receive continued support from the state because of their record in achieving significant positive impacts in tobacco control.

- You may hear some people with some confusion and frustration about the value of local public health... And so it's been kind of the sense that we're not as valued as many of us feel we should be in terms of the inroads we've made in tobacco control work. So it's been a little bit of a trying time I think for a lot of us in local health and in tobacco control... largely due to the economic duress that our state is in.

Partners recognized that due to budget cuts, an increased emphasis needed to be placed on efficiency, most notably through strengthening integration of the tobacco grant program with other chronic disease initiatives. However, partners felt that frequent CDC project officer turnover hindered their ability to smoothly implement this process. Partners felt that more communication with CDC would clarify how to integrate tobacco control with chronic disease.

- [We need] to integrate with other efforts, particularly in resource challenged times. If we're really looking at utilization of our resources, [then] multiple efforts working together rather than singularly [makes the most sense].
- There has been a lot of changing of the guards within CDC. I don't have direct contact, but with the whole integration effort of being one of four states that's on this journey to integrate... I feel like there's not absolute clarity about how tobacco control fits in with chronic disease.

Conclusions

Evidence-based guidelines played an important role in Colorado's tobacco control efforts. Colorado partners were aware of a number of guidelines and primarily looked to their recommendations when making decisions about their tobacco control efforts. Because partners perceived evidence-based guidelines' recommendations as proven to work, they relied on them to develop their work plans and defend their efforts. Additional factors that contributed to the adoption of evidence-based guidelines included:

- CDPHE served as a primary resource for evidence-based guideline dissemination.
- Evidence-based guidelines came from reputable sources, which provided credibility to efforts and helped partners justify their work to policymakers.
- *Best Practices* provided a framework for a comprehensive program and was used by partners to advocate for funding from policymakers and develop strategic plans.
- The *Community Guide* provided partners with examples of proven community health interventions for tobacco control and other public health areas, which helped guide their integration efforts.

Although evidence-based guidelines were mainly perceived as beneficial, partners noted some hindrances to guideline use:

- As the state was experiencing significant budget cuts, partners found it difficult to have a truly comprehensive program as defined by *Best Practices* and, therefore, struggled with determining how to prioritize funding allocation.
- Evidence-based guidelines lacked strategies on how to address specific populations with tobacco-related disparities.

An abundance of information is available to inform the work of those involved in tobacco control. Colorado partners utilized evidence-based guidelines and other resources such as the CDC, the Tobacco Review Committee, and internal and national data to aid in their tobacco control efforts. The degree to which particular evidence-based guidelines were incorporated into partners' work was dependent upon factors tied to three main phases of information diffusion highlighted throughout this report: dissemination, adoption, and implementation. Such factors included avenues of guideline dissemination to stakeholders, presence or absence of support by other individuals or policies, and the feasibility of applying that information to one's work. Colorado partners expressed a need for reliable direction and guidance to help overcome the continual challenges faced by tobacco control programs, such as prioritizing funding allocation during budget shortfalls and integration of tobacco control with other initiatives. Taking these factors into consideration when developing and releasing a new guideline will help to optimize use of the guideline by intended stakeholders.

